House of Representatives

General Assembly

File No. 362

February Session, 2014

House Bill No. 5578

House of Representatives, April 3, 2014

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE PROCESS FOR ADVERSE DETERMINATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (7) of section 38a-591a of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(7) "Clinical peer" means a physician or other health care professional who (A) holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and (B) for a review specified under subparagraph (B) or (C) of subdivision (38) of this section concerning (i) a child or adolescent substance use disorder or a child or adolescent mental disorder, holds a national board certification in child and adolescent psychiatry <u>where the covered person's treating health care professional is a psychiatrist</u> or child and adolescent psychology <u>where the covered person's treating health care professional is a psychologist</u>, and has training or clinical

experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or (ii) an adult substance use disorder or an adult mental disorder, holds a national board certification in psychiatry where the covered person's treating health care professional is a psychiatrist or psychology where the covered person's treating health care professional is a psychologist, and has training or clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

Sec. 2. Section 38a-591c of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) Each health carrier shall contract with (A) health care professionals to administer such health carrier's utilization review program, and (B) clinical peers to **[**conduct utilization reviews and to**]** evaluate the clinical appropriateness of an adverse determination.

(2) Each utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 38a-591b to assure such program's ongoing effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner. Each health carrier shall make its clinical review criteria available upon request to authorized government agencies.

(3) (A) Notwithstanding subdivision (2) of this subsection, for any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: (i) The most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria; or (ii) clinical review criteria that the health carrier demonstrates is consistent with the most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria, in accordance with subparagraph (B) of this

subdivision.

(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision shall create and maintain a document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the American Society of Addiction Medicine's Patient Placement Criteria, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the American Society of Addiction Medicine's Patient Placement Criteria.

(4) (A) Notwithstanding subdivision (2) of this subsection, for any utilization review for the treatment of a child or adolescent mental disorder, the clinical review criteria used shall be: (i) The most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument; or (ii) clinical review criteria that the health carrier demonstrates is consistent with the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument, in accordance with subparagraph (B) of this subdivision.

(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision for children and adolescents shall create and maintain a document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument.

(5) (A) Notwithstanding subdivision (2) of this subsection, for any

utilization review for the treatment of an adult mental disorder, the clinical review criteria used shall be: (i) The most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare; or (ii) clinical review criteria that the health carrier demonstrates is consistent with the most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, in accordance with subparagraph (B) of this subdivision.

(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision for adults shall create and maintain a document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare.

(b) Each health carrier shall:

(1) Have procedures in place to ensure that (A) the health care professionals administering such health carrier's utilization review program are applying the clinical review criteria consistently in utilization review determinations, and (B) the appropriate or required **[**clinical peers**]** individual or individuals are being designated to conduct utilization reviews;

(2) Have data systems sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(3) Provide covered persons and participating providers with access

to its utilization review staff through a toll-free telephone number or any other free calling option or by electronic means;

(4) Coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, processes for assessing member satisfaction and risk management; and

(5) Routinely assess the effectiveness and efficiency of its utilization review program.

(c) If a health carrier delegates any utilization review activities to a utilization review company, the health carrier shall maintain adequate oversight, which shall include (1) a written description of the utilization review company's activities and responsibilities, including such company's reporting requirements, (2) evidence of the health carrier's formal approval of the utilization review company program, and (3) a process by which the health carrier shall evaluate the utilization review company's performance.

(d) When conducting utilization review, the health carrier shall (1) collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination, and (2) ensure that such review is conducted in a manner to ensure the independence and impartiality of the **[**clinical peer or peers**]** individual or individuals involved in making the utilization review or benefit determination. No health carrier shall make decisions regarding the hiring, compensation, termination, promotion or other similar matters of such **[**clinical peer or peers**]** individual or individuals based on the likelihood that the **[**clinical peer or peers**]** individual or individuals will support the denial of benefits.

Sec. 3. Subsection (e) of section 38a-591d of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination.

(1) Such notice may be provided in writing or by electronic means and shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(A) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount;

(B) The specific reason or reasons for the adverse determination, including, upon request, a listing of the relevant clinical review criteria, including professional criteria and medical or scientific evidence and a description of the health carrier's standard, if any, that were used in reaching the denial;

(C) Reference to the specific health benefit plan provisions on which the determination is based;

(D) A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

(E) A description of the health carrier's internal grievance process that includes (i) the health carrier's expedited review procedures, (ii) any time limits applicable to such process or procedures, (iii) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (iv) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the covered person's benefit

request;

(F) If the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (i) the specific rule, guideline, protocol or other similar criterion, or (ii) (I) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, (II) instructions for requesting such copy, and (III) the links to such rule, guideline, protocol or other similar criterion on such health carrier's Internet web site. If the adverse determination involves the treatment of a substance use disorder, as described in section 17a-458, or a mental disorder, the notice of adverse determination shall also include, if applicable, a link to the document created and maintained by such health carrier pursuant to subdivision (3), (4) or (5) of subsection (a) of section 38a-591c, as applicable, on such health carrier's Internet web site;

(G) If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the adverse determination and (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances or (ii) a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation;

(H) A statement explaining the right of the covered person to contact the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include the contact information for said offices; and

(I) A statement that if the covered person or the covered person's

authorized representative chooses to file a grievance of an adverse determination, (i) such appeals are sometimes successful, (ii) such covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, **[**or from the Division of Consumer Affairs within the Insurance Department,**]** (iii) such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and (iv) such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (a) of section 38a-591n.

Sec. 4. Subsection (d) of section 38a-591f of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) (1) The written decision issued pursuant to subsection (c) of this section shall contain:

(A) The titles and qualifying credentials of the individual or individuals participating in the review process;

(B) A statement of such individual's or individuals' understanding of the covered person's grievance;

(C) The individual's or individuals' decision in clear terms and the health benefit plan contract basis for such decision in sufficient detail

for the covered person to respond further to the health carrier's position;

(D) Reference to the documents, communications, information and evidence used as the basis for the decision; and

(E) For a decision that upholds the adverse determination, a statement (i) that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, communications, information and evidence regarding the adverse determination that is the subject of the final adverse determination, and (ii) disclosing the covered person's right to contact **[**the commissioner's office or**]** the Office of the Healthcare Advocate at any time, and that such covered person may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time. **[**, or from the Division of Consumer Affairs within the Insurance Department.**]** Such disclosure shall include the contact information for said **[**offices**]** office.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 38a-591n.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-591a(7)
Sec. 2	*from passage*	38a-591c
Sec. 3	*from passage*	38a-591d(e)
Sec. 4	*from passage*	38a-591f(d)

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill makes several changes to private insurers' utilization review processes. As the bill addresses the operations of private insurance companies, there is no fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

HB 5578

AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE PROCESS FOR ADVERSE DETERMINATIONS.

SUMMARY:

This bill eliminates the requirement that health carriers (insurers) contract with "clinical peers" to conduct utilization reviews. It requires carriers to have procedures to ensure that appropriate or required individuals, rather than clinical peers, are designated to conduct these reviews. By law, clinical peers are health care professionals licensed in the same or similar specialty as the one that typically manages the medical condition, procedure, or treatment under review. Carriers must contract with health care professionals to administer their utilization review programs.

By law, the carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations (e.g., claims denials). The bill specifies that, when an urgent care request involves a child or adolescent substance use or mental disorder and the insured's treating health care professional is a child and adolescent psychiatrist, the clinical peer must also be a child and adolescent psychiatrist. In the case of adult substance use or mental disorders, the clinical peer must be a psychiatrist or psychologist, depending on the provider's profession.

By law, a carrier must notify an insured and, if applicable, his or her authorized representative, of an adverse determination. The bill eliminates the requirement that the notice state that the insured or representative may benefit from free assistance from the Insurance Department's Division (division) of Consumer Affairs. Similarly, the law requires the carrier to provide notice when an internal review of an adverse determination that was not based on medical necessity

upholds the initial decision. The bill eliminates the requirement that the notice disclose (1) the insured's right to contact the commissioner's office and (2) that he or she may benefit from free assistance from the division. The bill retains parallel notice requirements regarding the Office of the Healthcare Advocate.

The bill also makes conforming changes

EFFECTIVE DATE: Upon passage

BACKGROUND

Utilization Reviews

Utilization reviews are techniques carriers use to monitor the use or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Among other things, they can include monitoring or evaluating activities conducted to manage the care of patients with serious, complicated, or protracted health conditions or to review care on a prospective, concurrent review, or retrospective basis.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 19 Nay 0 (03/20/2014)